

Coming Out Through Art: A Review of Art Therapy With LGBT Clients

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Abstract

This paper examines sexual identity development and the integration of art therapy in counseling with lesbian, gay, bisexual, and transgendered (LGBT) clients. Especially during the coming out process for LGBT clients, research has shown that levels of emotional and physical well-being decrease considerably. However, there is growing evidence in support of a relationship between personal creative expression and sexual identity, as well as between expressiveness and physical and emotional health. This paper argues that the use of art therapy during the coming out process increases wellbeing in the LGBT population.

Introduction

Interest in the emotional and physical health of lesbian, gay, bisexual, and transgendered (LGBT) individuals has significantly increased over the past 30 years. Through this increased interest, research has found that LGBT clients are at increased risk for major depression, generalized anxiety disorder, eating disorders, panic disorder, alcohol dependency, drug dependency, poor self-esteem, and comorbid diagnoses when compared to the general population (Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Cochran, Sullivan, & Mays, 2003; Cole, Kemeny, Taylor, & Visscher, 1996; Remafedi, French, Story, Resnick, & Blum, 1998; Russell & Joyner, 2001; van Heeringen & Vincke, 2000), when compared to the general population. This increased risk is often attributed to the stress stemming from social stigma, discrimination, and the coming out process (Fife & Wright, 2000; Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002; Mays & Cochran, 2001; Otis & Skinner, 1996). As a result, LGBT individuals are proportionally more likely to present for mental health treatment and to use counseling services at a higher rate than individuals who do not identify as LGBT. For example, gay and bisexual men are nearly five times as likely to be treated for panic disorder and three times as likely to be treated for depression; lesbian and bisexual women are nearly four times as likely to be treated for anxiety or to develop a drug dependency (Cochran et al.,

2003). Similar findings have been noted regarding health issues that are often complicated by stress. Research suggests that LGBT clients have increased rates of diabetes, heart disease, and asthma (Diamant & Wold, 2003) as compared to non-LGBT clients, as well as an expedited progression of infectious disease (Cole et al., 1996).

Gay and lesbian adolescents report attempted suicide at rates approximately twice that of their heterosexual counterparts (Russell & Joyner, 2001; Safren & Heimberg, 1999). LGBT students face additional pressures in school as a result of their membership in a stigmatized minority: 84% report having been verbally harassed in school, 39% report having been physically harassed in school, 64% feel unsafe in their school environment, and nearly one third of LGBT students drop out of school as a result of harassment (National Education Association, 2005). The average high school student may hear anti-gay remarks at school as many as 25 times a day (Callahan, 2001).

The Coming Out Process

Many of the emotional and physical risk factors for LGBT individuals are most prominent during the process of coming out (Cole et al., 1996; Halpin & Allen, 2004; Vincke & Bolton, 1994). Coleman (1982) described coming out as beginning with "acknowledging a thought, or a fantasy" (p. 33). It is a process that often begins with recognizing homosexual feelings and then identifying to one's self and others as gay, lesbian, bisexual, or transgendered (Human Rights Campaign, 2004). Coming out is also a period of continually deciding whether or not to disclose this information to specific friends, family members, and coworkers (Anderson & Mavis, 1996; Griffith & Hebl, 2002; Mohr & Fassinger, 2003; Morrow, 1996; van Heeringen & Vincke, 2000; Waldner & Magruder, 1999). These decisions are motivated by the desire to validate one's own lifestyle and to establish authentic interpersonal relationships, while always balancing the potential costs of such disclosures.

Early understandings of the coming out process were based to a large degree on stage theories such as those developed by Cass (1979) and Troiden (1989). These theorists described coming out as occurring on average between the ages of 19 and 23 years of age, although the average age of coming out has become much lower in recent decades and individuals may come out to themselves and others at any point in the lifespan. Since the original publication of these stage theories, much has been written about understanding the coming out process, both in support of and in

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reaction to Cass and Troiden's proposals. Coming out generally corresponds with Cass's stages of Identity Tolerance and Identity Acceptance (stages three and four), where confusion about identity lessens but feelings of alienation and social difference often increase. During this time, individuals may detach from heterosexual support systems to seek out an LGBT subculture, which may be perceived as more accepting. If contact with LGBT support systems continue to increase, they can create an environment conducive to selective disclosure. New friendships and relationships built during this period may serve as sources of support when coming out to family members (Lewis, 1984). However, as researchers have critiqued stage models, they have found that the process is not a linear one; many variables interact when making a decision to come out. For example, those who enjoy particularly close familial relationships may postpone coming out, believing it to be more costly to go against their family's norms (Waldner & Magruder, 1999). Additionally, many people experience coming out as a continuous and lifelong process. This is especially true, for example, for bisexuals who are married to differently-gendered partners, because they face the additional challenge of countering assumptions of heterosexuality. As a result of these and other findings, researchers and theorists have moved toward embracing interactionist rather than stage models of understanding sexual identity and the coming out process. Such interactionist theories encourage taking into account potential biological, psychological, sociocultural, and historic factors in understanding the coming out process (Eliason & Schope, 2007). These approaches not only describe gay and lesbian identity and coming out more accurately, but they are much more inclusive of the coming out and identity formation processes of bisexual and transgendered clients.

Although LGBT individuals' feelings of confusion may decrease during coming out, feelings of alienation and social difference may increase as individuals experience detachment from heterosexual support systems in order to seek support from an LGBT subculture. Research has suggested that during the coming out process, levels of self-esteem, happiness, and life satisfaction decrease, whereas levels of loneliness increase (Halpin & Allen, 2004). As the coming out process begins to resolve and LGBT individuals progress further through their identity development, self-esteem, happiness, and life satisfaction grow and loneliness lessens. Tellingly, Vincke and Bolton (1994) identified the fact that low social support may be a contributing factor in low self-acceptance and depression.

It is also important to note that there are many factors that may affect the coming out process, such as age, ethnicity, and gender. Some of the early stage theories, such as Coleman's (1982), are now generally acknowledged to be most applicable to gay men, whereas more recently authors have discussed alternate theories of development for lesbian, bisexual, and transgender identity (Bleiberg, Fertman, Godino, & Todhunter, 2005; D'Augelli, 1994; Fassinger & Miller, 1996; Johns & Probst, 2004; McCarn & Fassinger, 1996). Newer research indicates that traditional linear models of sexual identity development do not adequately reflect

the often fluid experiences of women and young people (Diamond, 2000; Dubé & Savin-Williams, 1999; Rosario, Schrimshaw, & Hunter, 2004; Yarhouse, 2005). Racial and cultural differences play a role in the process as well, but although much has been written about race and sexual identity, relatively few empirical studies have been conducted. Racial differences may interact with the milestones of identity development, such as timing of identification as LGBT, commitment to that identity, and rates of disclosure to others (Dubé & Savin-Williams, 1999; Parks, Hughes, & Matthews, 2004; Rosario et al., 2004). For example, Parks et al. found that lesbians of color were less likely than White lesbians to disclose their sexual identity to someone outside of their families.

Coming Out and Creative Expression

Fischer (1972, as cited in Coleman, 1982) described a "cumulative effect" on overall health when self-expression is stifled. Since that time, others also have made a connection between self-expression and physical and emotional well-being (Berzonsky, 2001; Kivel & Kleiber, 2000; McDougall, 2001; Morris, Waldo, & Rothblum, 2001; Pachankis, 2007; Petrie, Booth, & Pennebaker, 1998; Talburt, 2004). This research has direct implications for art therapists working with LGBT individuals, where the most important aspect of their clients' self-expression often is the ability to come out and be out. For example, in a 1996 study of HIV positive men conducted by Cole et al., those who hid their sexual identity progressed from HIV to AIDS 20–40% faster than those who identified as mostly or completely out. Although HIV and AIDS are a concern for people of all sexualities, Cole's study aptly illustrates the potential health effects of stifled self-expression. More recently, Morris et al. (2001) found that the degree of "outness" proved to be an effective predictor of psychological distress and suicidality in lesbian and bisexual women.

Among adolescents who identify as LGBT, self-expression and virtual expression may play important roles in identity formation (Kivel & Kleiber, 2000; McKenna & Bargh, 1998). Leisure activities, in person and online, offer role models and role-playing opportunities for LGBT youth. Through books and magazines, Internet chat-groups, movies, television, sports, and music, LGBT adolescents are able to find others with whom they identify. By finding and emulating these others, they are able to "try on" various identities. In addition, self-expressive hobbies and interests offer new contexts in which to understand themselves in relation to gender and sexual norms. Finally, these activities provide a chance to find others "like" them and to develop a social network. Russell and Joyner (2001) concurred that the coming out process, although a significant challenge for LGBT youth, does usually offer the benefit of a new social system. These youth are able to "try on" an identity, to express themselves based on some degree of self-knowledge, and to decide whether it fits. The reverse can also be true; how individuals present themselves, whether or not their identities "fit," may affect self-perceptions (Berzonsky, 2001).

In planning counseling-based art therapy interventions with LGBT populations, several factors must be considered. Art therapists and other mental health professionals need to understand that homosexuality is no longer categorized as a mental illness or disease (American Psychological Association, 2005). The American Psychological Association, the American Association for Marriage and Family Therapy, the American Counseling Association, the Canadian Psychological Association, and the National Association of Social Workers all agree on this point, and have denounced reparative therapy¹, also known as conversion therapy. This knowledge should be at the heart of any therapist's work with LGBT clients. However, the LGBT population continues to face unique challenges—such as stress from stigmatization and discrimination—leading to emotional distress, substance use, and suicide, among other issues. Any of these may be addressed in art therapy with LGBT clients.

Furthermore, the ethical and accreditation standards of the above organizations mandate that all therapists who work with LGBT clients be adequately prepared for the needs of this population. These standards mandate competency in each of three areas: knowledge of LGBT issues, attitudes towards homosexuality, and skills with LGBT clients (Israel, Ketz, Detrie, Burke, & Shulman, 2003). Knowledge, attitudes, and skills include, but are not limited to, understanding homophobia and heterosexism, understanding sexual identity development, being non-judgmental and respecting differences, and being willing to discuss any aspect of their clients' lives. These competencies also apply to therapists who work in schools as they have a unique opportunity to affect the lives of LGBT students by helping them examine issues of identity, intimacy, power, autonomy, homophobia and transphobia, harassment, and the coming out process (Callahan, 2001). At the same time, art therapists must be able to understand when clients choose not to come out to others. The coming out process is associated with increased social judgment and isolation (Halpin & Allen, 2004). The assumption that being out is the only "healthy" way to be does a disservice to those who do not have the necessary emotional support or resources, who may not feel safe, or who simply are not ready. Defining mental health by level of "outness" actually may encourage internalized oppression in clients who are closeted (Talburt, 2004).

When clients do begin coming out, to themselves and/or to others, mental health professionals can be supportive in a variety of ways. During this period, LGBT adolescents are especially in need of support groups (to develop social skills; to discuss sexuality, sexual identity, and/or gender identity; to find support and understanding from peers; to share information; and to socialize), family

support, advocacy, health and social services, health education, role models and mentors (Gonsiorek, 1988), and career guidance (Browning, 1987). For bisexual clients, the PLISSIT model of counseling (Horowitz & Newcomb, 1999) may prove valuable when applied to art therapy, due to the unique issues that bisexuals bring, such as feelings of alienation from both homosexuals and heterosexuals, and uncertainty about sexual attractions for different genders. This model is made up of four parts: Permission (giving the client permission to explore a new identity), Limited Information (helping the client to sort out identity questions and validate new feelings by connecting the client with local resources), Specific Suggestions (which may include guidance about when to disclose to family and how to build a support network), and Intensive Therapy for a small number of clients for whom pathology interferes with their ability to function.

What has yet to be examined in the research literature is the effect of particular creative interventions such as art therapy on the coming out process. Several art therapists have pointed out the lack of research in their field, especially with respect to the LGBT population (e.g. Addison, 2003; Edwards, 1993; McNiff, 1998). However, many art therapy techniques are ideally suited for exploring identity issues and a number of case studies relate the value of art therapy to LGBT individuals (Addison, 1996, 2003; Bergin & Niclas, 1996; Brody, 1994, 1996; Fraser & Waldman, 2004; Sherebrin, 1996). For example, collage work has been used in individual and group therapy with gay men and lesbians to explore experiences with bigotry, hatred, internalized homophobia, and sexual identity (Addison, 1996, 2003; Brody, 1996). A weekly support group for low-income lesbians used art therapy to examine issues relating to relationship dynamics, trauma and abuse, socioeconomic class, lesbian identity and culture, visibility, gender issues, and transference (Brody, 1996). Activities for the group included self-portraits, collage, group murals, and sculpture, and the participants approached concepts of family, guilt, shame, fear, anger, and homophobia through individual and group art making. Fraser and Waldman (2004) described individual art therapy used with gay and lesbian clients struggling with sexuality, gender identity, depression, homophobia, coming out, fear, fantasy, and shame. For these individuals, art making was able to "make visible the invisible, hidden, and secret, to bear witness to pain and to celebrate courage" (Fraser & Waldman, 2004, p. 89).

Art-making techniques have also proven valuable for transgendered² individuals (Bergin & Niclas, 1996; Sherebrin, 1996), many of whom feel anxiety, confusion, or discomfort about their birth assigned sex and/or associated gender roles, often from a very early age. Through individual and group art therapy, other clients such as those with gender identity disorder can explore issues relating to gender, sexuality, shame, familial conflict, enmeshment, fear, anger, sadness, regret, rejection, disapproval, and discrimination. Transgendered identity (as well as the shame and discrimina-

¹Reparative therapy is based on the belief that homosexuality is an unacceptable choice, and one that can be "repaired." Research is accumulating to indicate that reparative therapy does not work, and in fact is damaging and unethical. See *Anything But Straight: Unmasking the Scandals and Lies Behind the Ex-Gay Myth* by Wayne R. Besen (2003) for more information.

²In this article, "transgendered" is used as an umbrella term for people who express gender in a non-traditional way.

tion that often accompany it) is built upon a binary model of sex—that one must be *either* male or female and that one's sex dictates one's behavior, attributes, and career options, among other things. An alternative model is provided by “queer theory,” based in part on the work of Judith Butler, which presents the idea that gender is not a fixed state (Butler, 1990). Queer theory conceptualizes gender as a continuum, with the constructs of “man” and “woman” at the ends and endless variation in between. For counselors of transgendered clients, this theory is crucial to understand. An in-depth discussion of queer theory can be found in Butler's (1990) *Gender Trouble* and Burdge's (2007) *Bending Gender: Ending Gender: Theoretical Foundations for Social Work Practice with the Transgender Community*.

Many art therapy interventions are ideally suited for clients struggling with identity. The activity “Inside Me, Outside Me” is one example, in which the client creates two self-portraits—one of the publicly presented self, the other of the private, internal, self (Makin, 2000). For LGBT clients in the early phases of coming out, these may be two very different portraits. The idea of creating self-portraits has been used by many clients in art therapy as a means for externalizing feelings and qualities of the self that are too delicate to expose verbally (Addison, 1996, 2003; Bergin & Niclas, 1996; Brody, 1994, 1996; Fraser & Waldman, 2004; Sherebrin, 1996). This activity may use a variety of media or take different forms, such as a mask or box (using the inside as well as the outside). Often these portraits are used as a springboard for discussion and reflection. Another activity involves puppet making, in which the created puppet “speaks” for the client. Some particularly shy individuals might feel freer to express what they are feeling through a proxy that is a representation of some part of themselves (Makin, 2000).

Art making during coming out may also prove valuable in strengthening a sense of emotional safety, in both individual and group formats. One example is the directive to choose an animal figurine and then create a “safe place” for it using a variety of art media, with the animal representing a part of the self that is kept safe in this environment (Brody, 1996; Makin, 2000). Collage also is appropriate for both individual and group art therapy, and may be a more accessible tool for those clients who are intimidated by the art-making process. Collages can be self-portraits or representations of self-in-community, with the use of words and phrases opening doors to discussion and discovery (Addison, 1996, 2003; Brody, 1994, 1996; Fraser & Waldman, 2004; Malchiodi, 1998). Additionally, research indicates that art therapy techniques are successful in treating anxiety, panic, hopelessness, and low self-esteem, regardless of the client's sexual orientation or gender identity (Ackerman, 1992; Albertini, 2001; Kennett, 2000; Peacock, 1991).

These are just a few examples of the potential of art therapy in this arena. However, some barriers to effective art therapy with LGBT clients do remain (Addison, 2003). In addition to the need for knowledge of LGBT issues, a non-judgmental attitude towards homosexuality and gender variance, and skills with LGBT clients, clinicians need to remain aware of the ways in which the outcomes or

products of art therapy may be different with this population than with heterosexual or normatively gendered clients. Symbols common to the LGBT community, such as upside-down pink triangles or rainbows may be prominent in a client's artwork. Part of being adequately prepared includes understanding this unique symbolism (Addison, 1996, 2003). Overall, there is much overlap between art therapy and traditional talk therapy. The use of creative art interventions with LGBT clients who are struggling with their public and private identities is valuable in helping them to learn about and become their authentic selves. Because the impact of creativity on the coming out process has not been empirically examined, the potential in this relationship deserves more research.

Conclusions

Currently, the American Art Therapy Association (AATA) does not publish specific guidelines for working with LGBT clients within its ethical document (2003). Nevertheless, art making has been used by many art therapists with LGBT clients to explore issues such as sexual identity, bigotry, internalized homophobia, trauma and abuse, lesbian identity and culture, visibility, sexuality, gender identity, depression, stereotypes and homophobia, and coming out. In addition, art therapy has been used with clients of all sexual orientations and gender identities to treat those mental health issues that are common for members of the LGBT community such as anxiety, panic, hopelessness, and low self-esteem.

For mental health professionals treating LGBT clients, certain core competencies are required for effective care: knowledge of the social, cultural, and health issues facing this population, a non-judgmental attitude, and skill in counseling LGBT clients. The art therapist should have an understanding of landmark and current theories of sexual and gender identity development. Also crucial to effective treatment is an awareness of social stigma, discrimination, homophobia, and transphobia, and the ways in which these factors threaten the emotional and physical health of LGBT clients.

Art therapy as used in the treatment of LGBT clients is an area that has been underexplored, but one that has much potential. The coming out process, in particular, is an area for further research that could benefit from the self-discovery process that is inherent in art therapy. By nurturing and expressing the imagination, clients in the midst of clarifying their sexual and gender identities may be able to protect their physical and emotional health while learning more about, and ultimately becoming, their authentic selves.

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